CAPTA Call
TECHNICAL ASSISTANCE FOR CAP GRANTEES

Grantees interested in participating in training workshops and follow-up onsite help may contact Audrey Smolkin (asmolkin@hrsa.gov) for referrals and further information.

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HIPAA PRIVACY CONSIDERATIONS

A diverse group of CAP grantees participated in a conference call on, to revisit the provisions of the HIPAA Regulation concerning privacy of health information. The Bush Administration has reopened the Regulation for comments until March 30, 2001. Policy changes are still possible throughout the comment period. The new date of publication is set for April 16, 2001, making the date of compliance April 16, 2003. The health care industry as a whole is (and cannot afford not to be) avidly interested in the Regulation's far-reaching requirements and its final form.

Since the Regulation's privacy provisions are extensive and complex, health care providers are seeking to develop systems that can handle its many permutations and to get a realistic picture of its probable effects on their day-to-day operations. To help clarify some of these issues, lawyers Robert Fulk, Michael Gloam, and Amy Wahl offered a useful analysis of pertinent information, as discussed within the following four questions:

Who is Covered by the Regulation?

There are three categories of covered entities:

- Health plans
- Health care clearinghouses
- Health care providers who transmit health information electronically

Health care providers who do not transmit health information electronically do not come under the Regulation. However, they become covered entities if they contract with vendors who provide electronic transmission for them. These "business associates" may be covered entities themselves. If they are not, the covered entity becomes responsible for vendor compliance the Regulation.

What are "Business Associates," as Defined by the Regulation?

Business associates are entities that perform functions involving individually identifiable health information on behalf of the covered entity or that have access to such information because of their association with the covered entity. They too must protect the privacy of the information. Though they may also be "covered entities," they are not necessarily so.

What Health Information Is Covered By The Regulation?

Protected health information (PHI) is any individually identifiable health information that is held or transmitted in any form – not only electronically, but also in writing and even verbally under some circumstances. The Regulation preempts state law regarding PHI only to the extent that the existing state law is less stringent. De-identified information does not come under the Regulation, but extreme care must be taken to be certain that such information cannot be re-identified.

What Constitutes "Permission" Under The Regulation?

Patients may give four types of permission, as described under the Regulation:

- Consent
- Authorization
- The opportunity to revoke all or part of their authorization
- The opportunity to agree or disagree with their health information

Consent is necessary for three things: treatment, payment, and health care operations, which cover a wide range of activities. Even when a database is already established, it is not wise to rely on previously obtained consents. Health care entities may have to segregate previously acquired information, and pre-existing consents may not be acceptable in all cases under the provisions of the Regulation. Exceptions to consent include emergency situations, cases where there is difficulty communicating but consent can be inferred, and cases when the law requires that an individual be treated.

The concept of authorization, which is required from an individual prior to disclosure of PHI, is outside the scope of consent. Treatment is not conditional upon providing authorization. Furthermore, there is a limit to an authorization (expiration), and an individual can revoke any part of her authorization at any time or even refuse to sign an authorization. Health care entities are responsible for developing ways to track such revocations and refusals. Significant penalties for unintentional and intentional disclosure are included in the Regulation.

An individual must also have the opportunity to agree or disagree with her record, and the health care entity must make other institutions that share this information aware of the individual's amendment. A patient can ask for an accounting of PHI that has been released, to whom and why – this is an essentially new requirement since the Regulation was published in December – and systems must be designed to meet this requirement. An individual may also restrict disclosure of PHI in some cases. Therefore, grantees must develop a process for managing these PHI requests.

Standards under the Regulation provide increased protection for individually identifiable health information. They also create new patient rights that make it necessary to develop systems with appropriate safeguards. For example, despite joint involvement in the care of an individual, multiple providers may not be able to share PHI without authorization. Therefore, providers may find it useful to work together to design a shared authorization form wherever possible. Common systems will diffuse the cost of meeting these requirements and functions may be shared. However, new risks to patient privacy can arise and care must be taken to ensure that PHI privacy is

maintained. Extensive training will be required at all levels of provider support and must include discussion of appropriate parameters for PHI implementation.

These new standards will clearly change the concept of privacy as it applies to protected health information and the systems that manage it. For continuing HIPAA developments, please visit http://aspe.hhs.gov/admnsimp/Index.htm.

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